

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH

County Queen Anne
Village or City Chester

Registration Dist. No. 253

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Marshall White Caridine Dellafine White Caridine

(a) Residence: No. Chester, Md. St. Ward.
(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5a. If married, widowed, or divorced
HUSBAND of Marshall Caridine
(or) WIFE of

6. DATE OF BIRTH (month, day, and year) 6-1-1880

7. AGE Years 55 Months Days If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Chester, Md.
(State or country)

13. NAME Richard Richardson

14. BIRTHPLACE (city or town) Chester, Md.
(State or country)

15. MAIDEN NAME ?????

16. BIRTHPLACE (city or town) ?????
(State or country)

17. INFORMANT Marshall Caridine
(Address) Chester, Md.

18. BURIAL, CREMATION, OR REMOVAL
Place Chester, Md. Date July 7, 1945

19. UNDERTAKER Lewis A. Henry
(Address) Cambridge, Md.

20. FILED July 14, 1945 F. C. Thomas Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

July 5, 1945
(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from

Jan. 13, 1945 to July 5, 1945
I first saw him alive on July 1, 1945; death is said

to have occurred on the date stated above, at _____ m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Pneumonia 3/10

Other Contributory Causes of importance:

Chronic Bronchitis 2/10

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____

(Specify city or town, county and State)
Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury _____

Nature of Injury _____

24. Was disease or injury in any way related to occupation of deceased? No.

If so, specify _____

(Signed) Samuel Price M. D.

(Address) Seventeenth St., Baltimore 7/14/45

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write *housewife* in answer to Question 8 and *own home* in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as *servant—private family*, *cook—hotel*, etc. For a person who had no occupation whatever write *none*.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as “employee,” “worker,” “operative,” etc. Find out the particular kind of work done and return that, as *spinner*, *weaver*, etc.

In stating the industry or business, avoid the use of such general terms as “store,” “factory,” “mill,” etc. State the particular kind of store, factory, mill, etc., as *grocery store*, *soap factory*, *cotton mill*, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as *civil engineer*, *mechanical engineer*, *mining engineer*, *stationary engineer*, etc. Avoid the term “laborer” when a more precise statement of the occupation can be secured. Do not use the word “mechanic,” but give the exact occupation, as *carpenter*, *painter*, *machinist*, etc. Distinguish carefully between *retail merchants* and *wholesale merchants*. A person who sells goods should be called a *salesman* and not a *clerk*.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
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Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Ran over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH



Reg. Dist. No. 252

1. PLACE OF DEATH:

County Queen Anne'sCity or town Centersville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne'sCity or town Centersville
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Nettie Carter

3. (b) Social Security Number

4. Sex Female5. Color or race Colored6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife John Charles Carter7. Birth date of deceased (mo., day, yr.) January ? 1878

8. (c) If alive, give age _____ years

8. AGE: Years 67 Months 6 Days ? If less than one day _____ hrs. _____ min.9. Birthplace Centersville Queen Anne's Co Md
(Town, county, and state)10. Usual occupation Housework

11. Industry or business

12. Name do not know13. Birthplace " " " "14. Maiden name do not know15. Birthplace " " " "16. Informant Bessie CarterAddress 52 W 117th St New York N.Y.17. Burial Date thereof July 23 - 45
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory CentersvilleLocation Centersville Maryland18. Funeral director Barton BrosAddress Centersville Maryland19. 7-21- 1945 Elvie Armstrong Centersville Md
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1945 at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 18 1945 to July 19 1945and that I last saw him alive on July 19 1945

Immediate cause of death _____

DURATION

Due to Pneumonia Pectoris

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. Henry Fisher

M. D. or other

Address _____ Date signed 7-21-45

CERTIFICATE OF DEATH

RECEIVED
JUL 25 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

CERTIFICATE OF DEATH

07230

★ Reg. Dist. No. 251

1. PLACE OF DEATH:

County Green Anne
 City or town Price
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 years
 Hospital, institution, or street address where death occurred:
Home
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Green Anne
 City or town Price
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Edward Scott Clough

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Eley L. Clough
 6.(c) If alive, give age 59 years
 7. Birth date of deceased (mo., day, yr.) Feb. 14 - 1872

8. AGE: Years 73 Months 5 Days 1 hrs. min.

9. Birthplace Green Anne Co. Ind.
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Ed. Spencer Clough
 13. Birthplace Green Anne Co. Ind.

MOTHER 14. Maiden name Mary C. Ringgold
 15. Birthplace Green Anne Co. Ind.

16. Informant Indis Ruth Clough
 Address Price Ind.

17. Burial Date thereof July 17 - 1945
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Church Hill
 Location Church Hill Ind.

18. Funeral director Edgar L. Lane
 Address Church Hill Ind.

19. July 16 - 45 E. L. Lane
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1945 at 8 4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 7 to July 15
 and that I last saw him alive on July 15

Immediate cause of death Myocardial Infarction DURATION 7 days

Due to Myocardial Infarction

Due to Myocardial Infarction

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide None Date of None

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) None

Means of injury None Injured at work? None

23. SIGNATURE Edgar L. Lane M.D. or other None

Address Church Hill Ind. Date signed July 16 - 45

RECEIVED
JUL 23 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07231

Reg. Dist. No. 252

1. PLACE OF DEATH:

County Queen Anne'sCity or town Centerville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 39 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne'sCity or town Centerville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)2.(a) if veteran, name war None

3. (a) FULL NAME

Thomas Nathaniel Davis

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Ida Lewis Davis

7. Birth date of deceased (mo., day, yr.)

December 17-1870

6. (c) If alive, give age _____ years

64

8. AGE:

Years

Months

Days

If less than one day

74626

hrs.

min.

9. Birthplace

Queen Anne's Co. Md

10. Usual occupation

Farmer

11. Industry or business

MOTHER FATHER

12. Name

Calvin Davis

13. Birthplace

Tackett Co-Md

14. Maiden name

Rebecca Robinson

15. Birthplace

Tackett Co-Md

18. Informant

Charles W Davis

Address

1405 Bergway Balts 22 Md

17.

(Burial, cremation, or removal, which?)

Date thereof

July 16-41

Cemetery or crematory

Christyfield

Location

Centerville Maryland

18. Funeral director

Darton Bros

Address

Centerville Maryland

19.

(Date rec'd by registrar)

July 16-1945 Elsie Armstrong

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 19 45 at 4:35 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

July 5 19 45 to July 14 19 45and that I last saw him alive on July 10 19 45

Immediate cause of death

Summery of Circumstances

DURATION

3-4 weeks

Due to

Tracheo-bronchitis of

Due to

Stomach

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op. _____

Autopsy results

no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

C. B. Layton MD

M. D. or other

Address Centerville Md Date signed 7-16-45

CERTIFICATE OF DEATH

RECEIVED
JUL 19 1945
BUREAU V.S.

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
JUL 7 1946
BUREAU V.S.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

07233

1. PLACE OF DEATH

County

Queen Anne's

Registration Dist. No.

253

Village or City

Loon Point

No.

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

2. FULL NAME

Charity E. Conland

(a) Residence: No.

St.

Ward.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

5a. If married, widowed, or divorced

HUSBAND of (or) WIFE of

Charles H. Conland

6. DATE OF BIRTH (month, day, and year)

11-4-59

7. AGE

Years

Months

Days

If LESS than 1 day, --- hrs. or --- min.

85

8

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

Housewife

10. Date deceased last worked at this occupation (month end year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town)

(State or country)

Blackwood, N.J.

MOTHER FATHER

13. NAME

William Conland

14. BIRTHPLACE (city or town)

(State or country)

Blackwood, N.J.

15. MAIDEN NAME

Mary Ann Battle

16. BIRTHPLACE (city or town)

(State or country)

Blackwood, N.J.

17. INFORMANT

(Address)

Mary Ellen Conland

18. BURIAL, CREMATION, OR REMOVAL

Place

Date

July 6

1945

19. UNDERTAKER

(Address)

G. L. Lane

20. FILED

July 4

1945

F. C. Thomas

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

July

(Month)

4

(Day)

1945

(Year)

22.

I HEREBY CERTIFY, That I attended deceased from

, 19

, to

, 19

I last saw him alive on

, 19

; death is said

to have occurred on the date stated above, at 12:30 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Cerebral hemorrhage

Date of onset

1 day

Other Contributory Causes of importance:

Name of operation

NO

Date of

What test confirmed diagnosis?

none

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide?

Date of injury

, 19

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

(Address)

M. D.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel, etc.** For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as “employee,” “worker,” “operative,” etc. Find out the particular kind of work done and return that, as **spinner, weaver, etc.**

In stating the industry or business, avoid the use of such general terms as “store,” “factory,” “mill,” etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill, etc.**

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer, etc.** Avoid the term “laborer” when a more precise statement of the occupation can be secured. Do not use the word “mechanic” but give the exact occupation, as **carpenter, painter, machinist, etc.** Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthma, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

Arteriosclerosis

Chronic interstitial nephritis

Cerebral hemorrhage

Other contributory causes of importance:

Gallstones

Date of onset

1915

1921

July 5, 1927

May 1, 1923

Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy

Run over by street car

Peritonitis

Other contributory causes of importance:

Gastroenteritis

Date of onset

1 week ago

1 week ago

3 days ago

1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:

County Queen AnneCity or town Heav Church Hill
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County Queen AnneCity or town Heav Church Hill
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Millard J. Thomas Gibson

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Alice K. Gibson

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

Aug. 10 - 1893

8. AGE:

Years

Months

Days

If less than one day

511120hrs.min.

9. Birthplace

Kent Co. Md.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

John H. Gibson

13. Birthplace

Kent Co. Md.

MOTHER

14. Maiden name

Mary J. Simpson

15. Birthplace

Delaware

16. Informant

Mrs. Alice Gibson

Address

Heav Church Hill Ind.

17.

(Burial, cremation, or removal, which?)

Date thereof Aug. 1 - 1945
(month) (day) (year)

Cemetery or crematory

Wesley Chapel

Location

Robt. Hill Ind.

16. Funeral director

Edgar L. Lane

Address

Chms Hill Ind.

19.

(Date rec'd by registrar)

19

45E. L. Lane

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 3045130AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1 to July 30and that I last saw him alive on July 29Immediate cause of death Coronary HemorrhageDue to HypertensionDue to NoneOther conditions None

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Edgar L. Lane

M. D. or other

Address

Date signed July 30

RECEIVED

AUG 4 1945

BUREAU U. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

Reg. Diat. No. 252

1. PLACE OF DEATH:

County JeffersonCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 yearsHospital, institution, or street address where death occurred:
Dead HouseHow long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State West Virginia County JeffersonCity or town Rural Frederick
(If outside city or town limits, write RURAL and give nearest town)Street No. None
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

William H. H. H. H.

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Thomas H. H. H.

7. Birth date of deceased (mo., day, yr.)

Aug 8 - 18826. (c) If alive, give age 59 years

8. AGE:

Years 67 Months 11 Days 12 hrs. None min. None

9. Birthplace

Frederick, West Virginia
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Same as occupation

MOTHER

FATHER

12. Name

William H. H. H.

13. Birthplace

Frederick, West Virginia

14. Maiden name

William H. H. H.

15. Birthplace

Frederick, West Virginia

16. Informant

James H. H. H.

Address

Frederick, West Virginia

17. Cemetery or cremation

Frederick, West Virginia

18. Funeral director

Frederick, West Virginia

Address

Frederick, West Virginia

19. Date rec'd by registrar

July 21 - 1945

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1945 at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

20 July 1945 and that I last saw him alive on July 19 1945

Immediate cause of death

Coronary thrombosis

Due to

Myocardial infarction

Due to

None

Other conditions

None

(Include pregnancy within 3 months of death)

Major findings of operations

None

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of NoneWhere did injury occur? None (City or town) (County) (State)Injured at home, farm, industry, public place (where?) NoneMeans of injury None Injured at work? None23. SIGNATURE James H. H. H. M. D. or other None Date signed July 20

RECEIVED
JUL 25 1966
BUREAU A. A.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (832)

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:

County Queen Anne'sCity or town Prince George
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Queen Anne'sCity or town Prince Station
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

William H. Hutson

3. (b) Social Security Number

4. Sex

m.

5. Color or race

w

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Mary Hutson

7. Birth date of deceased (mo., day, yr.)

Oct 16, 18676.(c) If alive, give age 54 years

8. AGE:

Years

Months

Days

If less than one day

7795

hrs. min.

9. Birthplace

Seedsburg Caroline Md.
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

John W. Hutson
Md.

13. Birthplace

MOTHER

14. Maiden name

Roscoe A. Prince

15. Birthplace

Md.

16. Informant

Wm. Mary Hutson
Wilmington Del.

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

July 28, 48
(month) (day) (year)

Cemetery or crematory

Mt. Olive

Location

near Seedsburg Md.

18. Funeral director

Raymond B. Rawlings
Seedsburg Md.

Address

19.

July 21, 48
(Date rec'd by registrar)48C. L. Lane

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 19 48, at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 5, 1948 to July 19, 1948
and that I last saw him alive on July 19, 1948

Immediate cause of death

DURATION

Myocardial infarction
3 hrs.

Due to

Myocardial infarction

Due to

Myocardial infarction

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ✓ Date of _____Where did injury occur? _____
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) ✓Means of injury ✓ Injured at work? ✓

23. SIGNATURE

Raymond B. Rawlings
Seedsburg Md.
Address _____ Date signed _____

RECEIVED

RECEIVED
AUG 1 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 193

CERTIFICATE OF DEATH

★ Reg. Dist. No. 252

1. PLACE OF DEATH:

County Queen Anne
 City or town Rural Centerville
 (If outside city or town limits, write RURAL and give nearest town)
5 hours
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Balto.
 City or town Baltimore Parkville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 7907 Elmhurst Ave.
 (If rural, give LOCATION)
 2. (a) If veteran, name war us ✓

3. (a) FULL NAME

Maurice Atwood Jones

3. (b) Social Security Number

none

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

single

B. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

January 7-1928

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

17613

hrs.

min.

9. Birthplace

Baltimore Maryland
(Town, county, and state)

10. Usual occupation

School

11. Industry or business

FATHER

12. Name

Alfred Jones

13. Birthplace

Chester 2d Co. Maryland

MOTHER

14. Maiden name

Florence Akers

15. Birthplace

Levick, Harford Co. Md

16. Informant

J. Alfred Jones

Address

7907 Elmhurst Ave. Balt. Md

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

July 23-45
(month) (day) (year)

Cemetery or crematory

Location

Baltimore Maryland

18. Funeral director

Barton Bros

Address

Centerville Maryland

19.

7-21-45
(Date rec'd by registrar)

19.

45 Elsie Armstrong
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 7-28-45 at 3 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death

Asphyxia

DURATION

1

Due to

Electricity

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

accident Date of 7-20-45

Where did injury occur?

Centerville 2d Co. Md
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

farm

Means of injury

Electricity Injured at work? yes

23. SIGNATURE

Samuel H. H. M.D.

Address

2000 N. Charles St. BaltimoreDate signed 7-28-45

RECEIVED
JUL 25 1945
BUREAU V. R.

M

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

72-1

CERTIFICATE OF DEATH

07238

Reg. Dist. No. 251

1. PLACE OF DEATH:

County Queen AnneCity or town Church Hill
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Life time

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen AnneCity or town Church Hill
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

George W. Massey

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) Aug. 25, 1885

6.(c) If alive, give age _____ years

8. AGE: Years 59 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Church Hill g.a. Ind.
(Town, county, and state)10. Usual occupation Painter

11. Industry or business _____

FATHER 12. Name Harrison Massey
13. Birthplace Kent Co. Ind.MOTHER 14. Maiden name Sarah C. McWhorter
15. Birthplace Kent Co. Ind.16. Informant Mrs. Maurice Smith
Address Church Hill Ind.17. Burial Date thereof July 28, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Church HillLocation Church Hill Ind.18. Funeral director C. L. Lane
Address Church Hill Ind.19. July 26 19 45 C. L. Lane
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25, 1945 at 7 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19, 1945 to July 25, 1945and that I last saw him alive on July 25, 1945Immediate cause of death Mitral Regurgitation

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. I CERTIFY George W. Massey M. D. Other _____Address Church Hill Date signed July 25, 1945

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
AUG 1 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1312)

CERTIFICATE OF DEATH

07239

Reg. Dist. No. 251

1. PLACE OF DEATH

County Prin. Barclay
 City or town Prin. Barclay
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 yrs
 Hospital, institution, or street address where death occurred:
no
 How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Prin. Anne
 City or town Prin. Barclay
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. no
 (If rural, give LOCATION)
 2 (a) If veteran, name war no

3. (a) FULL NAME

Adolph Plugge
 4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Sophie Plugge
 6. (c) If alive, give age no years
 7. Birth date of deceased (mo., day, yr.) unknown
 8. AGE: Years 72 (about) Months no Days no It less than one day no hrs. no min.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 19 45 at 7:15 P M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 14 19 45 to July 14 19 45 and that I last saw him alive on July 14 19 45
 Immediate cause of death Cerebral Anoxia
 Due to Chronic Hypertension
 Due to Chronic Hypertension
 Other conditions no
 (Include pregnancy within 8 months of death)
 Major findings of operations no

9. Birthplace Nebraska
 (Town, county, and state)
 10. Usual occupation Laborer
 11. Industry or business no
 12. Name John H. Plugge
 13. Birthplace Germany
 14. Maiden name Katherine Meyer
 15. Birthplace Prussia
 16. Informant Henry H. Cunnell
 Address Cumtville, Md
 17. Burial Burial Date thereof July 18, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Spring Hill
 Location Prin. Anne
 16. Funeral director W. H. Beck
 Address Prin. Anne
 19. 7/17 19 45 W. H. Beck
 (Date rec'd by registrar) Registrar

Autopsy results no
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide no Date of no
 Where did injury occur? no (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) no
 Means of injury no Injured at work? no
 23. SIGNATURE C. Nuttall M. D. or other no
 Address Prin. Anne Date signed 7/14/45

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JUL 21 1945
BUREAU V.M.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 928

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:

County Queen Anne
City or town Mc Kinnes Corner
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne
City or town Mc Kinnes Corner
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Louis High Jeat

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Marion Jeat

7. Birth date of deceased (mo., day, yr.) Jan. 11 - 1872 8.(c) If alive, give age _____ years

8. AGE: Years 73 Months 5 Days 25 If less than one day _____ hrs. _____ min.

9. Birthplace Queen Anne Co. Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Benjamin Jeat
13. Birthplace Queen Anne Co. Md.

MOTHER 14. Maiden name Clay. Hickerson
15. Birthplace Queen Anne Co. Md.

16. Informant Mrs. L. H. Jeat
Address Mc Kinnes Corner Md.

17. Burial Burial Date thereof July 10 - 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Basis Cem.
Location near Barclay Md.

18. Funeral director Edgar L. Lane
Address Church Hill Md.

19. July 10 19 45 Edgar L. Lane
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 M 45 19 45 at 12:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1945 and that I last saw him alive on July 30 1945

Immediate cause of death Myocardial Infarction DURATION 6 hrs

Due to _____

Due to _____

Other conditions Acute Myocardial Infarction
(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: if death was due to external causes, fill in the following: ✓
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ✓

Means of injury ✓ Injured at work? ✓

23. SIGNATURE Edgar L. Lane M. D. ✓
Address Church Hill Md. Date signed July 7

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 13 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The entire page is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 254

1. PLACE OF DEATH:

County Queen Anne
 City or town Grasonville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? all of life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)
 State Md County Queen Anne
 City or town Grasonville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3.(a) FULL NAME

John C. Williams

3.(b) Social Security Number

218-09-7923

4. Sex

Male

5. Color or race

Colored

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Grace Heath

7. Birth date of deceased (mo., day, yr.)

Feb. 24, 1882

6.(c) If alive, give age..... years

8. AGE:

Years	Months	Days	If less than one day
63	4	22	hrs. min.

9. Birthplace

Grasonville Md
(Town, county, and state)

10. Usual occupation

Waterman

11. Industry or business

Oysters + Fish

FATHER

12. Name

Nash Williams

13. Birthplace

Grasonville, Md

MOTHER

14. Maiden name

Mary Brown

15. Birthplace

Grasonville, Md

16. Informant

Archie Williams

Address

Grasonville, Md

17. Burial

Burial Date thereof July 18, 45
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Bryan Chapel Cemetery
Location Grasonville, Md

18. Funeral director

John D. Williams

Address

Easton, Md

19. 7-18

1945 Helen M. Aedridge
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1945 at 1:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 10. 1944 to July 16 1945

and that I last saw him alive on July 15 1945

Immediate cause of death

endocarditis mitralis
chronic

Due to acute regurgitation

Due to with decompensation

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE

Theodor Sattelmann M.D. or other
Address Stevensville Date signed July 17, 1945

RECEIVED
JUL 20 1945
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ Reg. Dist. No. 252

1. PLACE OF DEATH:

County Queen Anne's
 City or town Rural Centerville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 weeks
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Pennsylvania County Delaware
 City or town Drexel Hill
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 713 Edmondson Ave
 (If rural, give LOCATION)
 2. (a) If veteran, name war 2nd ✓

3. (a) FULL NAME

Nicola Maude Wright

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

William Wright

7. Birth date of deceased (mo., day, yr.)

July - 14 - 1871

8. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

7459

hrs.

min.

9. Birthplace

Turkey Creek, Pa
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Robert T. Moody

13. Birthplace

Wilmington Del

MOTHER

14. Maiden name

Sarah B. Huber

15. Birthplace

Philadelphia Pa

16. Informant

Address

Robert T. Newell
Centerville Maryland

17.

(Burial, cremation, or removal. Which?)

Date thereof

July 26-45
(month) (day) (year)

Cemetery or crematory

Arlington

Location

Drexel Hill, Pa

18. Funeral director

Address

Barton Bros
Centerville, Maryland

19.

(Date rec'd by registrar)

July 24-45
Elie Crematorium

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 7-7-45 at 4:15 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 14 to July 23 and that I last saw him alive on July 22

Immediate cause of death

Chronic valvular disease of the heart

Due to

Due to

Other conditions

arteriosclerosis

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury

Injured at work?

23. SIGNATURE

H. J. McPhersonM. D. or other Physician
Date signed 7/24/45

RECEIVED
JUL 27 1945
BUREAU V. S.